

# THE MEDICAL NEWS AND LIBRARY.

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**CLINICS.**  
**CLINICAL LECTURES.**  
*Clinical Lecture on a Case of Malignant Stricture of the Œsophagus.* Delivered at the London Hospital, Oct. 17, 1876. By C. F. MAUNDER, F.R.C.S., Surgeon to the Hospital.  
GENTLEMEN: You will recollect that while "going round" on Tuesday last I was requested by Mr. Mark Hovell, on behalf of Dr. Sutton, to see a patient with a view to performing gastro-stomachotomy. I will read the notes supplied by Mr. Hovell:—  
"James W., aged fifty-seven. Malignant stricture of the œsophagus. Admitted July 5; died October 12, 1876. Patient has been a fairly healthy man, but suffered occasionally from sick headache. No family history of tumours. The first time he noticed anything wrong

with his gullet was in May, 1875; and then, while having his dinner, found that one of the first mouthfuls he took (not an unusually large one) remained, after he had masticated and swallowed it, at a place in the œsophagus which he marked by pointing to about the middle of the sternum. He strained hard to swallow the morsel, but could not; then took several glasses of warm water, and after much retching succeeded in bringing the food up again, but he was so frightened at the occurrence that he went home and laid down. He ate his tea as usual that evening, and, as he had no subsequent trouble, gradually forgot the circumstance. Enjoyed good health for four months.

"In September, 1875, he noticed for the first time a sort of roughness in the œsophagus while swallowing, 'as if the food scraped him.' This scraping feeling

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gradually increased. In about a fortnight he felt as if there were something in his throat which prevented him from swallowing properly. Food seemed to go down for a certain distance, and then lodge, but on making a strong swallowing movement the food seemed to slip past the obstruction. This difficulty in swallowing slowly and steadily increased, and after a time food which had been swallowed was returned. This obliged him in February, 1876, to confine himself to liquid diet.

"In March he began to find that he could scarcely swallow liquids. He then went to a doctor, and a bougie was passed. After this he was able to swallow liquids for about another month, the stricture being kept open by a bougie passed two or three times a week.

"On admission, urine small in quantity, very cloudy, specific gravity 1019, acid; no albumen, blood, nor sugar. Brandy mixture two ounces, with the same quantity of milk and beef-ten, ordered to be given as an enema every four hours.

"He has been in great part fed by nutrient enemata since admission, and during the first month he was in hospital he gained three pounds in weight. A bougie has been passed from time to time, but the attempt to pass one about a fortnight ago failed, and subsequent attempts have been equally unsuccessful. For the last few weeks only three enemata have been given daily, and at times he could not retain them. The addition of twenty drops of laudanum to each enema, however, enabled him to hold them better. He gradually became more and more wasted, and at last, being unable to retain enemata, complained of distressing thirst and of his mouth being dry.

"On October 11 an operation was performed. He retained an enema the same evening, and one the following morning, but none after. He sank gradually, and died on the evening of the 12th."

I will take up the case from the time of my seeing it. On reaching his bedside I observed some urine in his *pôt de chambre* highly charged with blood, apparently a new feature in his case. Finding that the patient was deemed to be the subject

of a cancerous stricture of the œsophagus, I thought it possible the urinary tract might be somewhere similarly affected, and thought it right to postpone the operation that I might see Dr. Sutton upon the subject. You must recollect that healthy kidneys are believed to be essential to the success of a serious operation. Dr. Sutton saw me the next day, and requested me to perform the operation: for although the patient could not last many days, Dr. Sutton thought he would die easier if his intolerable thirst (a most distressing symptom) could be relieved. Dr. Sutton also thought that the blood in the urine might be accounted for by passive congestion consequent on extreme weakness. Both the patient and numerous friends were anxious for operative interference. I concurred with Dr. Sutton.

*Operation.*—In proposing to do this operation you will take care that your patient is not the subject of transposition of organs—a condition that has twice come under my notice—once in a dead subject and once in a living man. In the man under consideration the liver-dulness was natural, and the left hypochondriac region was markedly tympanitic, as though a distended stomach were there—its usual position. Great emaciation existed, with a receding abdomen. The patient was very feeble, having become unable to retain enemata, but he walked into the theatre. Chloroform was administered, and I made a longitudinal incision, from two to three inches in length, downwards from the point of the ninth rib and external to the sheath of the rectus muscle. Having divided the integuments and broad muscles *separatim*, I reached the peritoneum, and severed this to a similar extent, and exposed small intestine. This being my first case of gastro-stomachotomy (an operation rarely performed), I had, in searching for the stomach, to rely upon a preconceived notion of the sort of sensation which that organ would yield to my finger when touched by it. I hoped, also, to be guided to it either by the left lobe of the liver, or possibly by the spleen. I altogether failed to detect it; and, having already of necessity explored the

cavity to a degree inconsistent with the principle of *non-interference* (which I advocate and deem so essential to the success of abdominal surgery), I contented myself with opening what might be either colon or stomach. I called your attention to this important principle of non-interference, and illustrated its value by alluding to four cases—two infants and two adults—in which I had advised the making of an artificial anus by opening the abdominal cavity (gastro-enterotomy). Mr. McCarthy operated in one instance, myself in the other three. All recovered—a result I believe due to strict attention to special details. I was the less anxious to determine absolutely by more free exploration at the wound which viscus I was about to open, because, as the chief object of the operation was to relieve thirst, the injection of fluid could be made into either, though in larger quantities into the bowels; and it is a noteworthy fact that as the patient became unable to retain enemata, he complained more and more of thirst. The operation being completed, the patient was returned to bed, and died thirty hours subsequently.

At the post-mortem examination the anterior abdominal wall was cut away so as fully to expose the viscera. The artificial opening had been made in the transverse colon. The pyloric end of the stomach, empty and contracted, could be seen situated high up in the cavity. The left hypochondrium contained a hollow viscus, which Mr. McCarthy, who made the autopsy, at first thought was the distended stomach, but which proved to be the splenic angle of the colon; and this it was which yielded marked resonance on percussion prior to operation. This completely concealed the bulk of the stomach (quite empty and very contracted), which could only have been reached during life by tapping the intestine and dragging it down when collapsed. The intestines were greasy, as in the first stage of peritonitis. The middle of the œsophagus was the seat of cancer, and the right lung had a large nodule of a similar growth in it. The kidneys were congested, but no malignant deposit was

found in them; and thus the blood in the urine was explained.—*Medical Times and Gazette*, Nov. 11, 1876.

*Clinical Lecture on Stricture of the Urethra.*—Delivered at the Liverpool Royal Infirmary. By REGINALD HARRISON, F.R.C.S., Surgeon to the Infirmary.

GENTLEMEN: The practice of this infirmary affords you abundant opportunities of observing the surgical disorders of the genito-urinary system, and of these cases of stricture of the urethra and the complications arising out of it form no inconsiderable proportion. Associated as I have been for some years with two of the hospitals in this town deriving a large number of their patients from the seafaring population connected with the port, my observation leads me to believe that amongst this class of the community stricture is a common disorder. And that it should be so is not surprising. Gonorrhœa, contracted on shore, in the debauch that frequently precedes the vessel's departure for some foreign port, breaks out two or three days afterwards. Treatment, except in the case of certain passenger vessels, is usually conducted by the captain or his mate, and not always with advantage to the patient. The old notion that every disorder consequent on promiscuous intercourse is "venereal," and must be treated by mercury, still prevails; and large doses of calomel, until profuse salivation is produced, is not rarely the only remedy administered for a gonorrhœal discharge. Some of the worst cases of stricture that I have seen have been occasioned, under similar circumstances, by resort to the most primitive proceedings for the relief of retention of urine. In the absence of catheters from the ship's medicine chest, or still more frequently, as I have found, from their rottenness, I have known instances where the wire from a soda-water bottle and an iron skewer have done duty in "forcing" a stricture. It is only a short time ago when a man was admitted into No. 1 ward with retention and a badly lacerated urethra, as a consequence of an attempt on the part of the mate of his ship to reach the bladder by the aid of a pointed piece of wood,

roughly modelled to the shape of a bougie. In this instance the mate was more than professionally interested, inasmuch as he had occasioned the retention by kicking the patient behind the scrotum. The most remarkable piece of ingenuity some of you will remember as occurring a few months ago, where, after a sailor had endured for over three days the agonies of retention, an endeavour had been made to introduce through the urethra a piece of lead gas-piping, which had been devised, *in extremis*, for the purpose by the engineer of the ship. Unfortunately, however, this failed to effect the purpose. When I saw him on his arrival here, on the fourth day of retention, I found the urethra much lacerated, and it was with considerable difficulty that I introduced a catheter, and removed a large quantity of the most fetid urine imaginable. Relief, however, came too late, the man dying shortly after his admission with convulsions and uræmic poisoning.

Though deploring that persons should be placed by circumstances in such unfortunate positions, I mention these cases for the purpose of showing you that your field for observation in this department of surgery is by no means restricted to routine, or even to the freaks of nature or disease. In undertaking to say anything about the treatment of stricture, I am conscious that the subject is a well-worn one. Still, with all our plans of treatment, we have not arrived at anything like uniformity of practice, and as this is only to be obtained by taking the sum of our respective experiences, I feel less hesitation in bringing under your notice some conclusions which my own experience, chiefly gathered in the wards of this hospital, has enabled me to arrive at. These considerations I hope to place before you during my course of clinical lectures this session. In using the term "stricture," I reserve it, as Sir Henry Thompson suggests in his eminently practical work on Diseases of the Urinary Organs, for one kind of stricture: viz., organic stricture. "Spasm" and "inflammation" are conditions more or less transient, but do not constitute stricture in the acceptance of

the term which is now generally adopted. The causes of stricture are various. Let me give a few illustrations. A patient has a venereal sore on his glans penis involving the meatus. When this heals a cicatrix is left. Cicatrices are more or less disposed to contract, and in this instance result in the narrowing of the urethral orifice. This condition was well illustrated by a case in No. 7 ward, where the same state of things was produced by an improperly performed operation for circumcision; a portion of the glans penis having been removed along with the prepuce. When the sore healed, the cicatrix contracted, and the patient presented himself here with a tight stricture of the meatus requiring division. Another cause of stricture amongst our sailor patients arises from injuries where the urethra becomes bruised or lacerated. A man falls from aloft across a spar or a rope, and ruptures his urethra. If the patient recovers from the immediate effects of the injury, it is with his urethra scarred. Here we have the worst variety of stricture—traumatic—a form of the disorder more obstinate to deal with than any other. In our inquiries as to the cause of stricture, we find that by far the larger proportion of our patients attribute their misfortune, directly or indirectly, to previous attacks of gonorrhœa. Those who do so *directly* are disposed to look upon the stricture as the natural consequence of their previous mishap. Those who do so *indirectly* usually have something to say about the treatment employed and its bearing upon the subsequent formation of a stricture. It is worth our while for a moment to analyze the statements made by this latter class with the view of ascertaining how far their allegations hold good. "I was almost cured of my gonorrhœa, only a very slight discharge remaining, which I thought would go away of itself," is the statement of the patient who is convicted of his own indiscretion in having allowed things to go on from bad to worse. Others, again, seek refuge in referring their misfortune to the improper advice they have received. "I was told that it was only a gleet, due to weakness, which

would go away by iron, tonics, and cold baths." Here we have illustrations of gleet terminating in stricture.

Now it is well for you, once for all, to understand that a gleet is not a disorder which is disposed to go away of itself; on the contrary, it requires careful and well considered treatment, and if it does not receive this—that is to say, if it is clumsily dealt with or not dealt with at all—it most probably ends in the formation of a stricture.

A gleet is to be regarded as indicative of the early formation of stricture. Nay, further, you will not do wrongly in regarding a gleet as the stage in the stricture-forming process when by your treatment you can promise your patient to restore his urethra to its normal condition; when a stricture is once allowed to become cicatricial in its character, you may palliate or adapt, but you can no more *restore* his urethra than you can by dissection or any other process remove a scar from his skin. You may moderate the inconveniences of a scar, but you cannot obliterate it. Let not, then, the curable stage of stricture pass by; at all events, let the onus of doing so rest with your patient, and not with yourself.

Again, it is very common to hear patients attribute their strictures to the use of injections in the treatment of their gonorrhœas. A considerable amount of prejudice exists in the public mind in reference to the use of these applications. Patients not unfrequently say, when consulting you about a gonorrhœa, "Do not order me an injection, as I understand they often occasion stricture." Is there any truth in such an allegation? Assuredly not, presuming, of course, injections are judiciously prescribed and properly used.

Let me remind you that the cure of gonorrhœa by specifics is essentially one on the principal of injection. For how do the drugs that act specifically on the urethra effect their purpose? How do we explain the action of copaiba, oil of sandal-wood, creasote, and certain terebinthines, in the cure of gonorrhœa? Do not all these drugs exercise their therapeutic properties, by certain of their con-

stituents, for the most part demonstrable, being conveyed by the urine to the situation of the disorder? What is this but a cure by injection, or, to be etymologically correct, *ejection*? It is the urine of the patient that conveys the specific to the disease, just as the rose-water in your injection does the sulphate of zinc, or other astringents.

It is the abuse of injection that is open to animadversion. Injections in the treatment of gonorrhœa only do harm when, by reason of their composition or strength, they act as *irritants* to the mucous membrane.

In the ordering of urethral injections there are two rules which should be regarded: 1. Do not strain the urethra by the *quantity* of injection used. 2. Do not pain the urethra by the *quality* of the injection. A teaspoonful of fluid *put* into the urethra frequently is better than a tablespoonful *forced* in three times a day. This is a point upon which I have long insisted. In prescribing injections you should feel your way, adding to the strength according to circumstances. Some persons, it is well known, are far more sensitive to the action of remedies than others; and this applies equally to the urethra—"The temper of the urethra varies as much as the temper of the mind."<sup>1</sup> An injection appropriate in strength to a first gonorrhœa is like the proverbial drop of rain on the duck's back in the case of the *habitué*. I remember ordering one of the latter an injection well known as "the four sulphates." It cured him effectually, and without pain. A friend, hearing of the success, borrowed the prescription, and, without proper advice, used it. The consequences were, an acute attack of cystitis and a subsequent stricture. Surely it is only to the foolhardiness of the sufferer that such an unfortunate result is to be attributed.

And I would here remark that I have seen a great deal of damage done and suffering occasioned by the use of some of the nostrum injections advertised throughout the country as "infallible cures" and "preventives." Many of them contain

<sup>1</sup> Brodie on Diseases of the Urinary Organs, p. 60.

the ordinary astringents applicable to the urethra, but in a very potent form. I caution you therefore against sanctioning their use.

These observations have been made with the view of showing that it is only by their improper use that injections are open to the charge of occasioning stricture. If they are prescribed in accordance with the rules I have given, you will never have cause to regret their use.

[Mr. Harrison then proceeded to speak of the pathology of stricture, illustrating his remarks by cases which have recently been under treatment in the infirmary.]—*Lancet*, August 19, 1876.

#### HOSPITAL NOTES AND GLEANINGS.

*Popliteal Aneurism cured in two hours by the application of Esmarch's Bandage.*—D. M'H., labourer, æt. 29, was admitted into Manchester Royal Infirmary under the care of Mr. F. A. Heath, Oct 16. He stated that up to within three weeks of his admission he enjoyed good health. While at his work about that time he experienced a weakness and pain in the calf of his leg, and noticed a lump behind the knee, which throbbed a good deal, and gave him some pain. He had never had syphilis, but had been a pretty heavy drinker at times. On admission an aneurism, the size of a small orange, was found occupying the left popliteal space. It pulsated freely, and a distinct bruit could be heard in it. The tibial arteries at the left ankle could not be felt, but were plainly perceptible at the right ankle. The veins on the surface of the left leg were larger than those on the right, but there was no cedema of the limb. Heart-sounds perfectly healthy, and area of cardiac dulness normal.

Oct. 17. At 10.15 A. M., after the limb had been elevated to empty it of blood, Esmarch's elastic bandage was carefully applied from the toes upwards, until the lower part of the popliteal space was reached. The patient was then directed to stand up in order to allow blood to flow into the aneurism, and the bandage was then lightly passed over it, a layer of cotton-wool intervening. The roller was

then applied above the knee to within three inches of Poupart's ligament, where it was secured. Temperature 98.6°; pulse 80. At 11 A. M., the patient was somewhat restless, and complained of great pain in the limb. One-third of a grain of morphia given subcutaneously. At 11.15 A. M., temperature 98.6°; pulse 90; Signoroni's tourniquet applied to the femoral artery in Scarpa's triangle, and Esmarch's bandage, having been on exactly one hour, was slowly removed; tumour felt hard, and no pulsation could be perceived in it. The leg and toes looked blue, and felt cold. The limb was enveloped in cotton-wool and flannel bandages to maintain the temperature. Pain was relieved on removal of Esmarch's bandage, and the patient appeared very cheerful. At 12.15 P. M., all pressure was taken off for a few moments, exactly two hours after the operation had been commenced. The tumour was quite hard, seemed a little smaller, and no trace of pulsation could be felt in it. A small vessel was noticed pulsating over the aneurism near to the external side; tourniquet reapplied. At 2.15 P. M., pressure was again removed for a short time; no pulsation in the tumour. At 4.15, just six hours after Esmarch's bandage was applied, the tourniquet was entirely removed, and the tumour on being examined was found to be quite hard, and free from pulsation. The patient was not in any pain. The tourniquet was applied lightly over the femoral artery, so as to control, but not to stop, the flow of blood.

18th. 9.30 A. M.: Tumour much smaller and quite hard; no trace of pulsation to be felt in it. Limb quite warm. Three small arteries to be felt pulsating in front and at inner side of knee-joint.

19th. Tourniquet entirely removed. Aneurism hard and getting smaller.

Mr. Heath was led to adopt this method of treatment from the account which appeared in *The Lancet* of the 30th Sept. of the success attending a case of Mr. Wagstaffe's, and his account was followed step by step during the operation. It may fairly be assumed that the aneurism was cured at the end of the second hour, for the tumour was quite hard and free from

pulsation at the end of that time.—*Lancet*, Nov. 4, 1876.

*Peculiar Luxation of the External Extremity of the Clavicle.*—The luxation of the clavicle directly backwards over the acromion is a form which is rarely seen. In neither "Malgaigne" nor the "Dictionnaire Encyclopédique des Sciences Médicales" is any mention made of it.

Michael H—, aged eighty-one, shoemaker, native of Antwerp, came to the hospital, complaining of inability to use his right arm. On the 7th September, while crossing the street, his foot slipped as he was getting on to the pavement, and he fell on to the back part of his shoulder.

At first sight the case appeared to be one of luxation of the head of the humerus forwards, several of the symptoms of that form of displacement being present. But upon closer examination it was easy to determine that the head of the humerus had not left its cavity, and that there was in reality a luxation of the clavicle, and not of the humerus.

The symptoms were briefly as follows: In front the internal extremity of the clavicle was prominent, the inferior and superior clavicular fossæ were effaced, and the distance between the middle line and the shoulder was diminished. At the shoulder the head of the humerus was found to be in its normal position. The articular surface of the acromion was found to be situated in front of the clavicle. Behind the acromion the external extremity of the clavicle could be readily distinguished. The articular surface of the latter was situated outside the acromion, and its anterior border corresponded with the posterior border of the acromial process. The head was slightly flexed, and turned towards the right. The elbow was separated from the body by a distance of ten centimetres. The spinal border of the scapula was prominent, and its inferior angle was pushed towards the spinal column. The movements of the arm were very limited, and caused much pain.

The patient was put under the influence of chloroform with the view of reducing

the luxation, but this was found to be impossible; accordingly his arm was fixed in a sling.

M. Nicaise, who was doing duty at that time for M. Péan, proceeded to make some experiments upon the dead body, in order to determine the mode of production of this form of luxation. With the section of the acromio-clavicular ligament it was impossible to produce the luxation. The trapezoid ligament was then cut, and it was then found easy to produce the desired displacement. The conoid ligament was left intact. From these experiments it may be inferred that the rupture of the trapezoid ligament is necessary for the production of this form of luxation.—*Lancet*, Oct. 14, 1876.

## MEDICAL NEWS.

### ORIGINAL ARTICLES.

*Further Report of a Case of Sanguineous Discharge from the Vagina of an Infant aged three months.* By EDWIN FARNHAM, M.D., Cambridge, Mass.—The urine of the mother of the child, Mrs. S., was examined three times, chemically and microscopically, and at no time were any evidences of renal trouble discovered.

Since the case was reported the child has developed an eruption of hereditary syphilis. On investigation of the family history it appears that about six years ago the father had a chancre and a bubo which suppurated. The mother has at no time given any indication of infection.

The infant has been weaned, and put upon a mercurial course, the drug being exhibited in the form of hydrargyrum cum creta. Under this treatment it has thriven, the eruption fading, and the child increasing in weight, though not so rapidly as before weaning. The weight (naked) when five months old (Nov. 7th, 1876) was 15 pounds.

Whether the development of such a disease as hereditary syphilis throws any light on the causation of the vaginal discharge I am unable to decide.

By a misprint it is stated in the preceding Number of the *News*, that the mother suffered during her pregnancy from Toxic convulsions instead of *Tonic*.

## DOMESTIC INTELLIGENCE.

*Johns Hopkins Hospital, Baltimore.*—

The trustees of this institution have been so fortunate as to obtain the services of Dr. John J. Billings, Assistant Surgeon, U. S. A., as professional adviser. This excellent appointment is another proof of the good judgment which the management has so far conspicuously displayed in the performance of their difficult task.

*International Congress of Ophthalmology.*

—This Congress met in New York on the 12th of September, pursuant to adjournment at London in 1872. The following officers were elected. *President*, E. Williams, M.D., of Cincinnati; *Vice-Presidents*, Mr. Brudenell Carter, of London, and Dr. E. Hansen, of Copenhagen; *Secretary*, Dr. C. S. Bull, of New York. A number of interesting papers were read before the Congress, and will appear in the volume of *Transactions*. A committee consisting of Mr. Carter and Drs. Hansen and Becker were appointed to designate, after consultation, the place of meeting in 1880.

*Honors to American Physicians.*—Mr.

WILLIAM ADAMS, President of the Medical Society of London, inaugurated the winter session by delivering an address in which he gave a graphic and complimentary account of his visit to America as a delegate to the International Medical Congress. He concluded by proposing as corresponding fellows of the society, Drs. S. D. Gross, of Philadelphia; Austin Flint, of New York; Joseph Pancoast, of Philadelphia, and Surgeon-General Barnes, U. S. A.

*Deaths from Chloroform.*—The *Ohio Medical Recorder* for October, 1876, reports a case of death from the inhalation of chloroform occurring in a young woman aged 30, to whom it was administered for the extraction of a tooth.

Another case is reported in the *Pacific Medical and Surgical Journal* for the same month. The patient was a man who resided in Madison County, Indiana, and the anæsthetic was administered for the purpose of extracting a thorn from his foot.

Dr. W. T. McNUTT reports (*Pacific Med. and Surg. Journal*, July, 1876) a case of this which occurred during the reduction of dislocated shoulder joint.

*International Medical Congress.*—We are requested to state that gentlemen who wish to obtain early copies of the forthcoming volume of *Transactions of the International Medical Congress*, held in Philadelphia, September 4-9, 1876, should forward their subscriptions without delay to the treasurer, Dr. Caspar Wister, 1303 Arch St., Philadelphia.

The price, to subscribers, is SIX DOLLARS (\$6 00) per copy, payable in advance; but this rate will be considerably increased upon the day of publication.

*OBITUARY RECORD.*—Died in Pittsburg, Oct. 14th, 1876, of pneumonia, A. G. WALTERS, M.D., aged 65 years. Dr. Walters was a bold operator, and enjoyed a large practice. He was a native of Russia, and a graduate of the University of Berlin, but has resided in this country since 1836.

—August 16, 1876, JULIAN S. SHERMAN, M.D., Professor of Orthopedic Surgery and Diseases of the Joints in the Chicago Medical College.

## FOREIGN INTELLIGENCE.

*Carbolic Acid as a Local Anæsthetic.*—

Dr. BERGONZINI recommends a new painless mode of opening abscesses. It consists in placing in contact with the skin for three or five minutes a mixture formed of one part of glycerine and two parts of carbolic acid. It produces neither redness nor swelling, and may be employed with advantage in autoplasmic operations, and in the treatment of superficial neuralgia.—*Med. Times and Gazette*, Oct. 21, 1876, from *Presse Méd. Belge*, Oct. 8.

The anæsthetic properties of carbolic acid were first pointed out more than four years ago by Dr. J. H. Bill, U. S. Army, in an interesting paper in the *Am. Jour. of the Medical Sciences* for July, 1872.

*Administration of Sulphate of Quinia.*—

Dr. DORVILLE prescribes from one-half to one gramme in a small glass of brandy at the commencement of the cold stage, to

arrest the paroxysm or prevent subsequent attacks. In a moderate dose the action of the quinine is rapid and energetic, and its taste so taken is not very disagreeable.—*Med. Times and Gazette*, Nov. 4, from *Union Méd.*, Oct. 19.

**Poison of Non-edible Mushrooms.**—Dr. SCHIFF has demonstrated that these have a common poison, muscarina, and that its effects are counteracted by both atropia and daturia.

**Experiments on Filtration.**—Mr. J. A. WANKLYN states that on continuing his experiments on the action of "Silicated carbon" filters, he has obtained results beyond his most sanguine expectations.

A solution of sulphate of quinine of such a strength that one gallon contained 8.26 grains of soluble sulphate of quinine ( $C_{20}H_{24}N_2O_2H_2SO_4 \cdot 6H_2O$ ) was completely deprived of quinine by one single filtration through six inches of filter.

The liquid before filtration yielded 3.55 milligrammes of albuminoid ammonia per litre, and after filtration 0.02 milligrammes of albuminoid ammonia per litre.

A solution of the above strength is sensibly bitter to the taste, and after filtration is no longer bitter.

Chemists will thus perceive that the silicated carbon filter is endowed with extraordinary powers.

That carbon has some power in absorbing alkaloids has been known for years (*vide* Watts's Dictionary); but that it absorbs alkaloids absolutely and almost instantaneously is new. A fresh powdered silicated carbon filter must be an excellent antidote in poisoning cases.—*The Sanitary Record*, July 8, 1876.

**Utilization of Paris Sewage.**—Since 1868, the Paris sewage has been employed to irrigate the large plain of Gennevilliers, which is inclosed by the windings of the Seine. This irrigation has converted the arid soil of this plain into a market garden of extraordinary fertility. No one disputes this, but it has been alleged that the sewage has acted injuriously upon the population of the district. An investigation, instituted by Dr. Bergeron, has proved the groundlessness of this statement, for with an increased population

the longevity has also augmented, and the mortality declined. The water from the wells which has filtered through the soil is found quite void of organic matters.—*Med. Times and Gazette*, Oct. 28, 1876, from *Révue Méd.*, Oct. 9.

**Smallpox.**—London is threatened with an epidemic of this disease. The fatal cases of this disease, which were but 7 during the first quarter of this year, rose to 26 in the three months ending June, and further increased to 84 in the eleven weeks ending on the 16th of September.

During October the mortality of the disease diminished; the number of deaths during the week ending Oct. 28 was 15, as compared with 11, 16, and 22 in the three weeks immediately preceding. But in the week ending on the 4th of November the deaths mounted up to 21. The most unfavourable feature, says the *Lancet* (Nov. 11) of this week's return, is the wider distribution of the fatal cases. Further, on the 4th of November, the two Metropolitan Asylum District Smallpox Hospitals contained 231 inmates against 185 the preceding week. No less than 101 new cases were admitted during the week; the highest weekly number of admissions since the beginning of the present epidemic being 62.

**University of Edinburgh.**—Dr. GRAINGER STEWART has been elected Professor of Medicine to fill the vacancy caused by the death of Prof. Laycock.

**School of Medicine of Paris.**—It is stated (*L'Union Médicale*, Oct. 17th) that the city of Paris has commenced operations for the enlargement of this school. The size of the school will be tripled.

**Canadian Medical Association.**—This Society held its annual meeting at Toronto in August. The next meeting will be held in Montreal on the second Wednesday in September, under the presidency of Dr. Hingston of that city.

**OBITUARY RECORD.**—Died Sept. 21st, 1876, of phthisis pulmonalis, aged 64, THOMAS LAYCOCK, M.D., Professor of the Practice of Physic in the University of Edinburgh.

## PROSPECTUS FOR 1877.

The continued favor bestowed on the "AMERICAN JOURNAL OF THE MEDICAL SCIENCES" and its adjuncts enables the publisher to maintain for 1877 the very liberal terms offered during the past year, and encourages the Editors in the effort to render these periodicals, if possible, indispensable to every reading physician.

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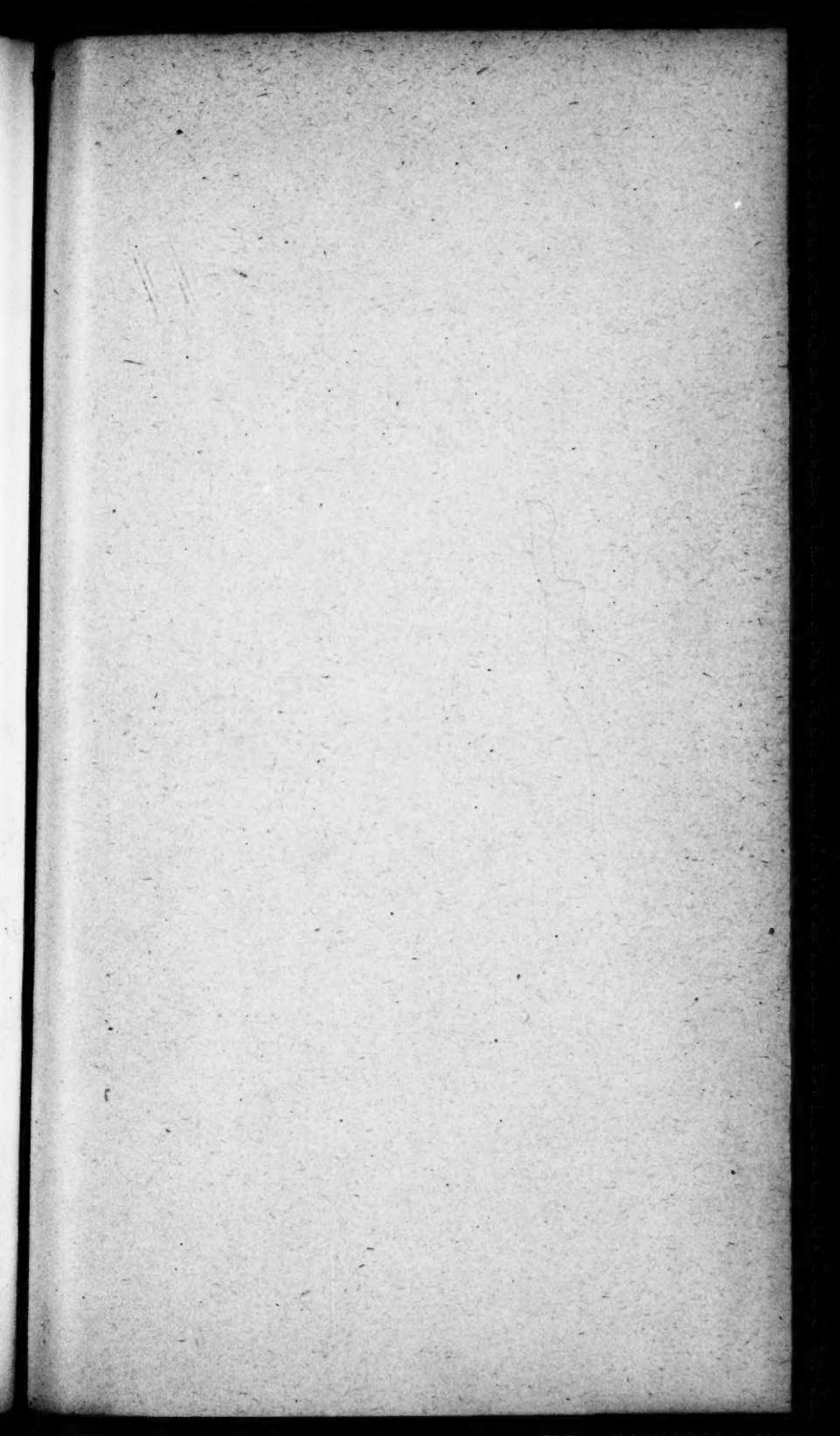
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